STRATEGIES TO BUILD HARM REDUCTION CAPACITY IN INDIVIDUAL PRACTICE, ORGANIZATIONS & COMMUNITIES

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HRETA
Harm Reduction Education & Technical Assistance

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AGENDA

01 - FAMILIARIZE

Short introduction to the HRETA team's past & current projects

02 - CONTEXTUALIZE

Explore the HR movement, the environmental context of SUD and SUD services and understand relevant theories

03 - STRATEGIZE

Assess and discuss levers to build our individual & collective abilities to increase HR capacity in our environments

HRETA PROJECT: BRIEF

The Harm Reduction Education & Technical Assistance (HRETA) project utilizes Academic Detailing, an educational outreach model, to engage NH-based professionals & provide the evidence that supports harm reduction related behavioral/practice changes. Initially funded by NH DHHS via OD2A monies, most recently funded by NACCHO & the CDC

- The HRETA project is a collaboration between the **UNH Department of Nursing** and **the New Hampshire Harm Reduction Coalition**
- Since its incipiency in 2019, the HRETA team has engaged **~500 participants in 1:1 AD sessions** and **600+ in harm reduction trainings**
- Different phases have had different foci, including
  - *Healthcare professionals*
  - *Pharmacies & ERs*
  - *Communities & PHN regions*
  - *Elected officials* **(current)**
- The HRETA project team has **developed numerous audience-specific resources**, including snapshots of each NH's 13 PHN regions

REGIONAL SNAPSHOTS BY NH PHN

NH Nursing

HRETA Harm Reduction Education & Technical Assistance

CAPITAL REGION

This snapshot summarizes narrative findings from learning sessions held with key regional stakeholders identified by the Public Health Networks and community agencies. Data sources are listed under corresponding infographic.

1. NARRATIVE SUMMARIES FROM REGIONAL 1:1 MEETINGS

INVOLVE PEOPLE WITH LIVED EXPERIENCE IN PLANNING & EVALUATION

Some peer mentorship programs reported; peers are the first point of contact when entering the Doorway. The majority of organizations report staff members in recovery or using surveys in their quality improvement plans. Experience-based co-design used in regional planning (FORE grant).

PROVIDING NON-STIGMATIZING SERVICES

Organizations have people with lived experience as staff, training provided by people with lived experience is seen as important in fostering understanding. Motivational interviewing trainings widely conducted. Cultural humility trainings are reported across region. Access to language line services is reported in Concord.

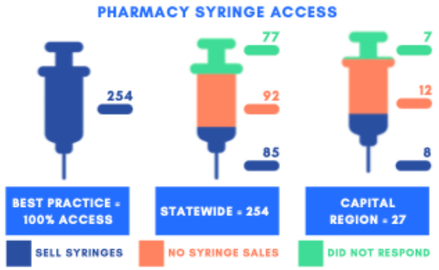
COLLABORATION ACROSS THE CONTINUUM OF CARE

Strong partnerships with the Doorway reported by all organizations. Uniquely, EMS is very engaged via Project First. Coordination among agencies is strong, especially with the Capital Area Leadership Team.

INFECTION PREVENTION

Collaboration with Public Health Network to provide services, especially for vaccinations and information for clients. Transportation is noted as a barrier for clients. The Doorway has been helpful for vaccinations, infection prevention. Access to sterile injection equipment limited, multiple agencies report that a local syringe service program (SSP) is needed in region.

2. PHARMACY SYRINGE ACCESS



SOURCE: SURVEY OF ALL NH RETAIL PHARMACIES CONDUCTED BY UNH IN 2020 (N= 174: TOTAL NH RETAIL PHARMACIES = 254; RESPONSE RATE 68.5%)

3. SYRINGE SERVICE PROGRAM (SSP) ACCESS

SYRINGE SERVICES PROGRAM ACCESS

NO SYRINGE SERVICES PROGRAM IN REGION

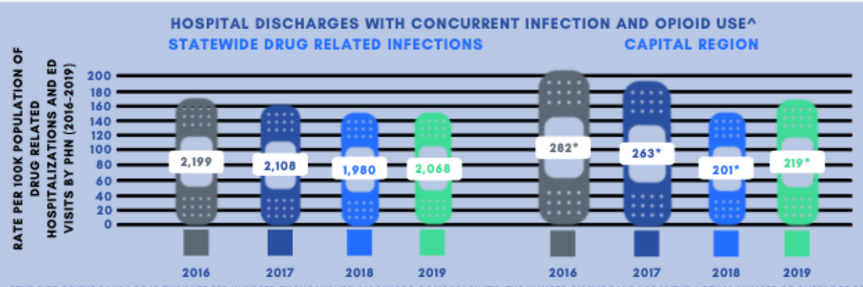
DISTANCES TO CLOSEST*

- 17.9 MI MANCHESTER
- 35.3 MI ROCHESTER
- 35.6 MI NASHUA

*DISTANCES TO CLOSEST SYRINGE SERVICES PROGRAMS FROM PUBLIC HEALTH NETWORK IN CONCORD, NH

SOURCE: SYRINGE SERVICE PROGRAMS REGISTERED IN NH, VT, AND ME

4. HOSPITAL DISCHARGE DATA



*THE SIZE OF THE BANDAGE IS THE RATE PER HUNDRED THOUSAND, TO ALLOW FOR COMPARABILITY. THE NUMBER ON THE BANDAGE IS THE ACTUAL NUMBER OF OVERDOSE DEATHS.
SOURCE: OFFICE OF HEALTH STATISTICS AND DATA MANAGEMENT, BUREAU OF PUBLIC HEALTH STATISTICS AND INFORMATICS, NH DEPARTMENT OF HEALTH AND HUMAN SERVICES
^INCLUDED CASES OF CELLULITIS, ABSCESS, SKIN INFECTION, BACTEREMIA, SEPTIC ARTHRITIS, OSTEOMYELITIS, OR ENDOCARDITIS AND OPIOID USE, OPIOID ABUSE, OPIOID DEPENDENCE, OPIOID POISONING, OR ADVERSE EFFECT OF OPIOID

1. NARRATIVE SUMMARIES FROM REGIONAL 1:1 MEETINGS

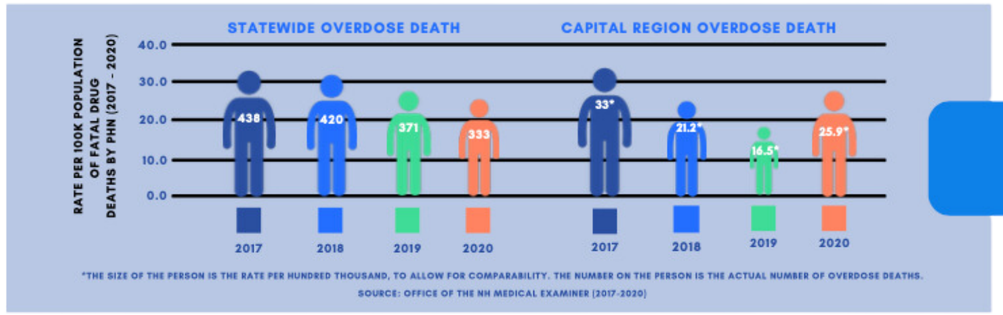
ACCESS TO NALOXONE

All partners report sufficient access to naloxone. Acknowledgment t
are reversing overdoses without calling 911, state-reported overdose
underreported. Multiple organizations do street outreach including
distribution in Concord.

REFERRAL TO SUD TREATMENT SERVICES

Doorway engaged in referrals with community partners, opportuniti
engage with more treatment providers. Shortened turnaround time a
removal needed to enable immediate access to treatment. More Inte
Outpatient Program (IOP), detox, and residential treatment services
in region. New Recovery Community Organization (RCO) coming to Co

5. FATAL OVERDOSE DATA



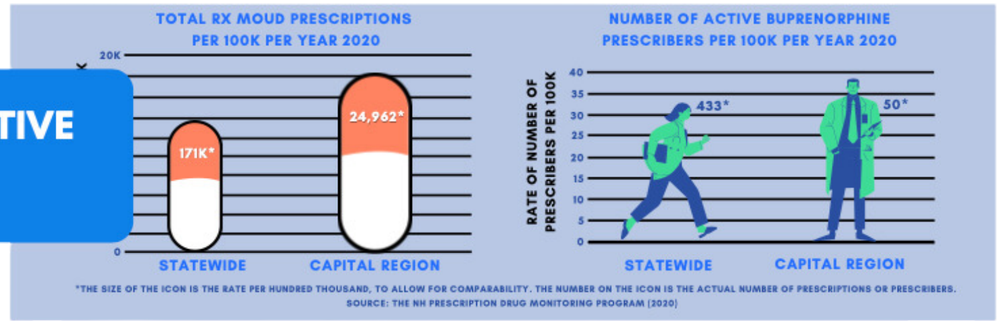
HOUSING

Need for greater access to low-barrier housing, no subsidized housing available. Long waitlist for shelters and housing, 8-10 year waiting list for Section 8. Some organizations provide hotel vouchers, but there is stigma reported and concerns about housing COVID-positive folks in hotels.

ACCESS TO MEDICATIONS FOR OPIOID USE DISORDER (MOUD*)

Multiple options/programs for medicationS for opioid use disorder (MOUD) throughout the region. Stigma in the community reported for MOUD, some see it as "enabling"; opportunities exist for provider and community education. One MOUD friendly sober living facility.

6. MOUD PRESCRIPTIONS & ACTIVE BUPRENORPHINE PRESCRIBERS



IMPACT OF COVID-19

Increase in telehealth allowing for low-barrier access at a critical time, but there are barriers in access to tech and tech literacy. Street outreach more limited. Increase in homelessness noted.

ACADEMIC DETAILING

(AD) is a **1:1 engagement model** originally used by pharmaceutical reps to educate prescribers on the efficacy of a particular drug. It has since been adapted as an educational outreach strategy to deliver the evidence-base of different medical treatments.

- Series of brief, interactive sessions that cultivate trust between detailer & detailee, interactive sessions that cultivate trust between detailer & detailee
- Delivers the latest evidence-based support and education for managing common but challenging care conditions
- Tailored to the needs, interest and time frame of participants
- Objective is adoption of desired behavior change (ex: refer patients to SSPs)

HARM REDUCTION

A practical set of strategies and ideas aimed at reducing negative consequences associated with drug use that include but are not limited to:

COLLABORATING

Working with PWUD to minimize the harmful effects of drug use, rather than ignoring or condemning them

UNDERSTANDING

Conceptualizing drug use as a complex & multi-faceted phenomenon that encompasses a continuum of behaviors

RECOGNIZING

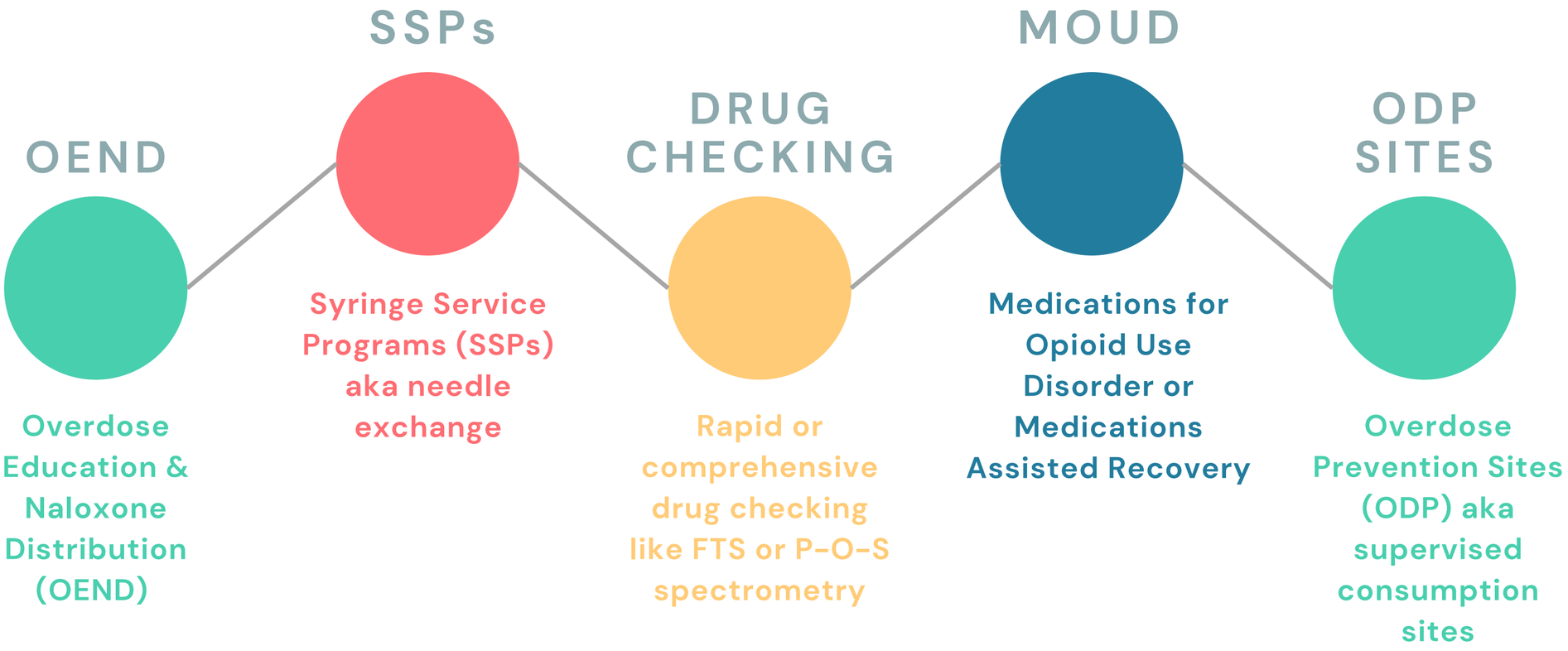
Acknowledging the factors that affect people's vulnerability to & capacity for effectively managing drug-related harm

COMPASSIONATELY SERVING

A call for the non-judgmental, non-coercive provision of services and resources to people who use drugs

Worksheet Q1

PUBLIC HEALTH
HARM REDUCTION STRATEGIES



Worksheet Q2

ORIGINS OF HARM REDUCTION

LIBERATION

Grassroots, radical philosophy. PWUD, sex workers & trans activists **self-advocating** decades before PH adoption

SELF-DETERMINATION

Led by PWUD, centers self-determination & body autonomy. Non-coercive, do not force people to change

MUTUALISM

Values community, support one another in healing root causes of harm. **Relationships are reciprocal**

CRITIQUES OF PUBLIC HEALTH HR

DISPROPORTIONATE IMPACT & HARM [1,2]

People of color are disproportionately impacted by overdose deaths & face higher rates of drug-related arrest, prosecution and incarceration

SELECTIVE RACIALIZED DECRIMINALIZATION [3]

War on Drugs = criminalization of drug use, led to mass incarceration
Opioid Epidemic = PH emergency led to Good Samaritan Laws, medicalization of Bupe

PATERNALISTIC & PROFESSIONALIZED [4, 5]

PH HR emphasizes professionals as the experts, excludes PWUD & can strip core values of self-determination, self-advocacy and peer leadership as the relationship is often one-directional

Locality	Pop.[6] (2021)	OD Deaths [7] (2022)	Rate p/100k pop	Pop % White Alone	Pop% Black Alone
NH	~1.39M	434	3.2	92.8%	1.9%
Manch.	111,462	96	**8.6**	80.3%	**6%**
Nashua	91,124	51	**5.6**	79.2%	**3.6%**
Concord	44,006	19	**4.3**	87.8%	**3.4%**
Roch.	32,869	18	5.5	92.7%	1.0%
Berlin	9,704	11	**11.3**	91.0%	**6.8%**

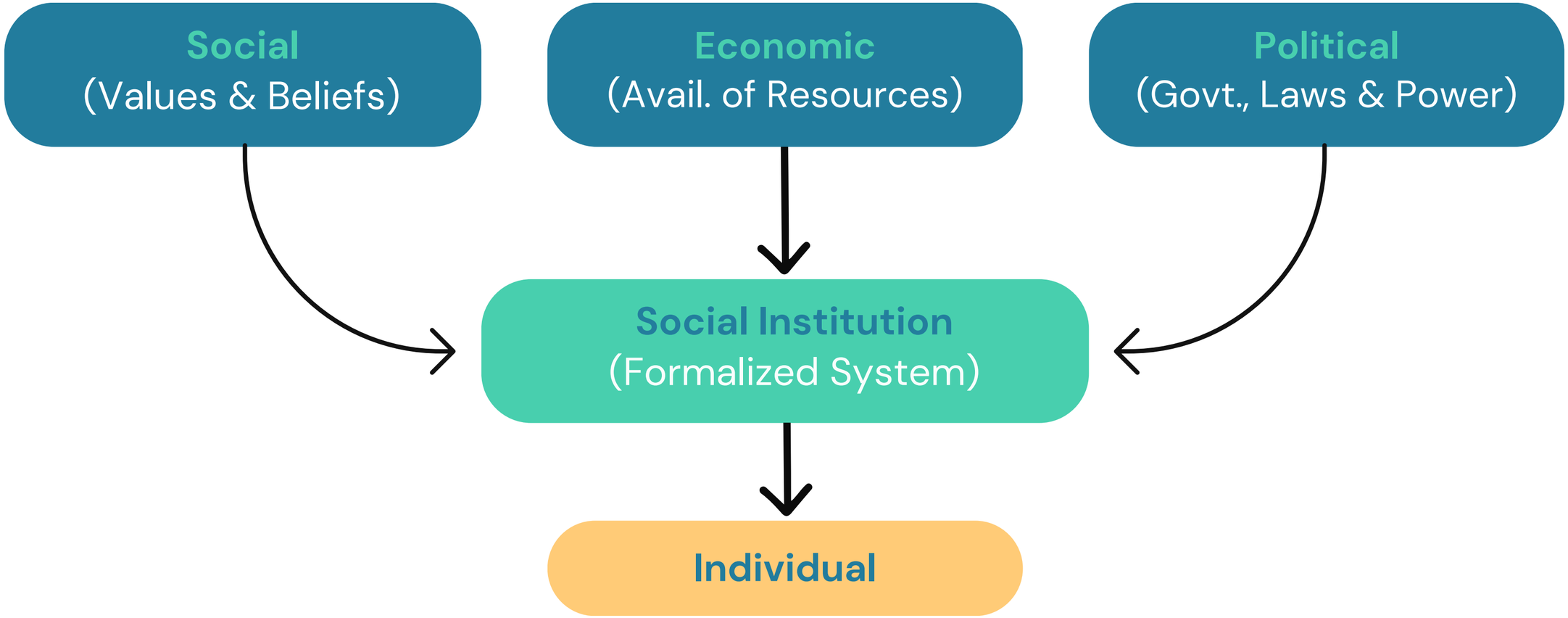
[1] (Panchel et al, 2021) [2] (Daniels et al, 2021) [3] (Levins, 2021) [4] (Castillo, 2019) [5] (Hassan, 2023) [6] (US Census Bureau, 2023) [7] (NH DMI, 2023)

THEORY TIME

Contextualizing Human Behavior & Power at the Systems Level

$$B = f(I,E)$$

THE SOCIAL ENVIRONMENT



(Kirst-Ashman, 2019)

THE SOCIAL ENVIRONMENT

Social

Values & beliefs held by people in the social environment that are strong enough to influence how governments are structured or restricted

Economic

Availability of resources and how they are distributed & spent. Like taxes at the national level, or how salaries are distributed

Political

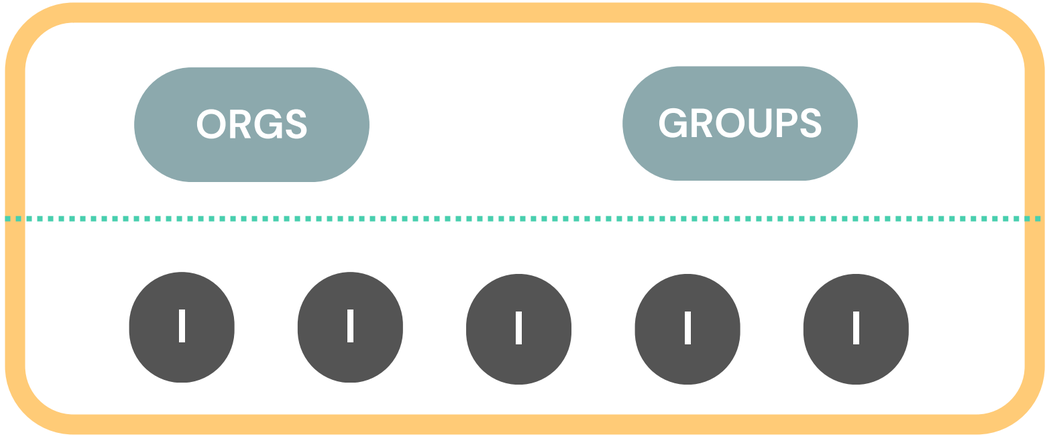
Current govt. structures, the laws we are subject to & the distribution of power among the population. Reflected in laws, policies, & decisions elected officials make about the distribution of resources

Social Institutions

SEP forces converge over time to form **social institutions**, which are established and valued practices or means of operation in a society resulting in the dev. of a formalized system

Communities

Communities provide the environments for social institutions to be upheld and are composed of **organizations** and **groups** that carry out policies & distribute the services deemed necessary by the social institution, all of which impact **individuals**



(Kirst-Ashman, 2019)

THE SOCIO-ECOLOGICAL MODEL

The SEM framework demonstrates the multiple levels of influence that impact a person's behavior, such as substance use, as well as the multi-level interventions that can be used to modify behavior.

INDIVIDUAL

Individual sociodemographic factors such as health & mental health, biological & physical domains

COMMUNITY

Community & immediate context in which a person lives affects their daily behaviors in critical ways.

INTERPERSONAL

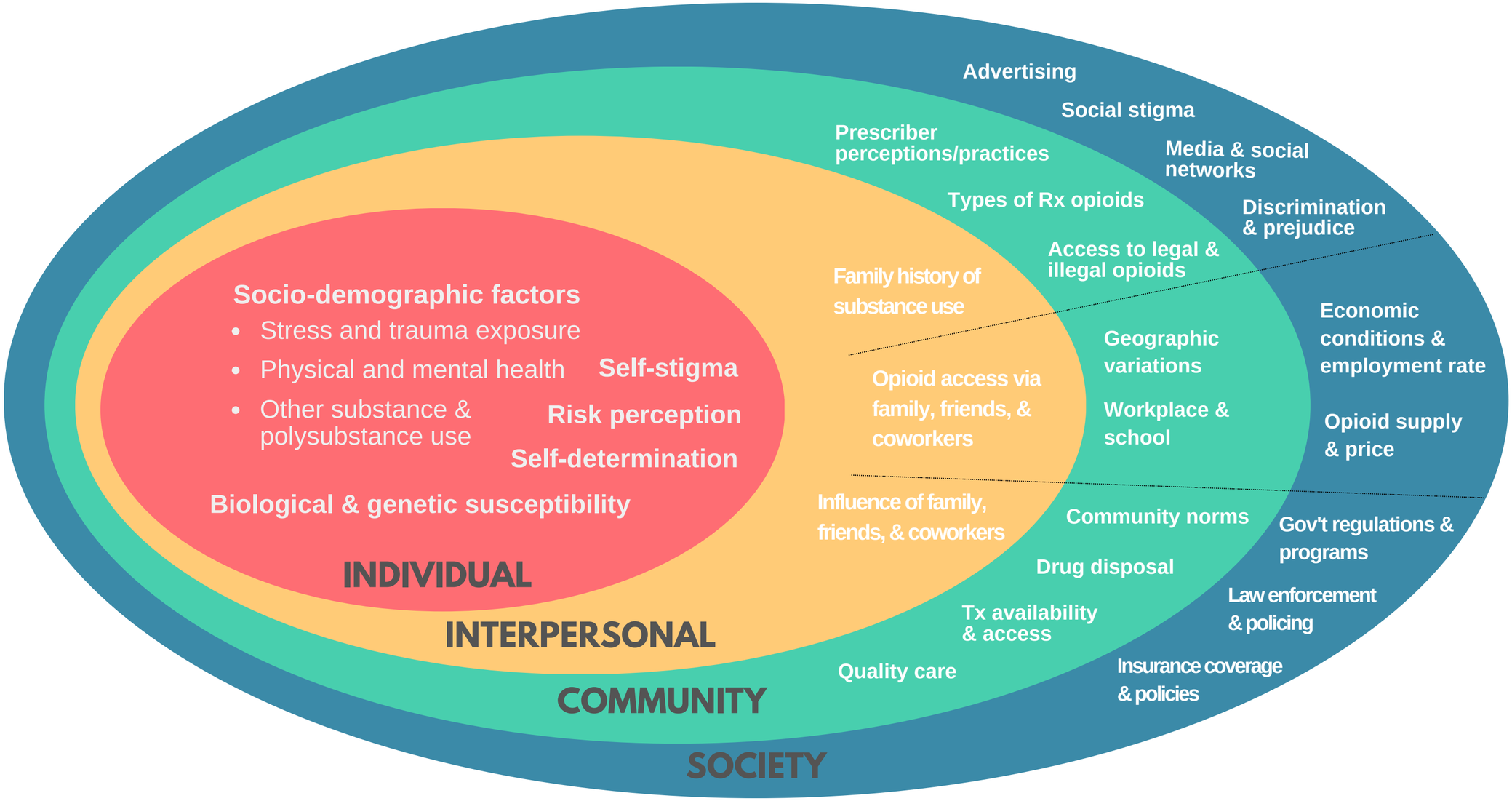
Family, friends, and social networks significantly shape the beliefs, attitudes, and behaviors of individuals

SOCIETY

As previously described-prevailing social, economic, and political forces coalesce in social institutions, all of which influence individual behavior

(Bohler, Clark & Horgan, 2021)

SEM & THE OPIOID CRISIS: MAJOR FACTORS OF OPIOID MISUSE



(Jalali et al, 2020)

POWER

The potential ability to move people of a chosen course of action to produce an effect or achieve some goal

7 Main Sources of Power in Communities

KNOWLEDGE

The power of information. Insights into an issue or access to ideas and allies. Can be controlled, as in the flow of information.

REPUTATION

Character as power. It is easy to be persuasive & to influence people when they admire and/or respect your abilities.

DECISION-MAKING

Agency as power. Anytime & anywhere an individual has access to processes that affect other people without power.

WEALTH

Money as power. People with money have more choices, more autonomy. Money affects social interactions. A lack of money limits our access to power.

HIGH STATUS

Positionality as power. Doctors, lawyers, judges, academics and elected officials etc. all derive power from high-level social positions.

LAWS & POLICIES

Rules as power. People who make and enforce the regulations that govern others hold enormous power over others.

CONNECTIONS

Proximity as power. Interpersonal connections and networks are sources of power that are commonly leveraged for influential purposes.

Worksheet Qs 3 & 4

(Kirst-Ashman, 2019)

POWER

The potential ability to move people of a chosen course of action to produce an effect or achieve some goal

5 Bases of Power in Organizations

INFORMAL

REFERENT

Power of Personality. Based on respect and admiration of an individual earned from others over time. Maintained through likeability and social adeptness.

EXPERT

Power of Knowledge. Advanced knowledge in a field or other speciality based on education and/or experience. Not dependent on formal position or social status, rather on the informational influence & credibility of the the person.

FORMAL

LEGITIMATE

Power of Authority. The legitimate right to prescribe behavior or beliefs for a person. Based on predetermined hierarchical structure. Ability to hire, fire, delegate, etc.

REWARD

Power of Positive Reinforcement. The ability to give or withhold performance-based rewards as incentives. Based on motivating others & creating positive working environments.

COERCIVE

Power of Punishment. The ability to penalize others or remove positive existing elements. Based on fear as a means of control Examples include publicly shaming, withholding information, exclusion, harassment, threatening to terminate etc.

Worksheet Q5

(Kovach, 2020)

STRATEGIES

To Increase Harm Reduction Capacities in Our Environments

TWO EXAMPLES OF BUILDING HR CAPACITY

WINNIPESAUKEE

Our findings from Phase III informed a project which targeted the Winni region for HR AD (high rates of overdose deaths, hospitalizations for drug-related infections, and lack of syringe access & disposal).

In conversations, many folks from disparate orgs. expressed desire to establish an SSP. HRETA convened all interested parties and facilitated a conversation with NHHRC re logistics & technical assistance.

The group, with representation from the Doorway, Navigating Recovery (RCO), RPHN, FQHC, Community Mental Health, CAP and others, pooled resources & took action.

DOVER

Due to complaints from business owners regarding improperly discarded syringes, a small working group formed comprised of reps from SCPHN, SOS (RCO), the Doorway, NHHRC, HRETA, and community volunteers.

The group conducted research, interviews and meetings with external stakeholders like DPD, HR consultants etc. This resulted in a proposal to pilot anonymous sharps disposal in two locations that was presented to city council.

Responsibilities were divided according to capacity and skill sets. City council voted unanimously to pilot. Must wait til next year's Summit to hear more!

Five C's

GET CURIOUS

CHALLENGE THE STATUS QUO

COLLABORATE

CREATIVELY PROBLEM SOLVE

CEDE THE POWER

GETTING CURIOUS (AND UNCOMFORTABLE)

In order to increase capacity and support for harm reduction, we need to critically reflect on what we're doing well, gaps that exacerbate unmet needs, and opportunities for improvement-at the individual, organizational & community level. We must also identify ways to minimize institutional harm.

1. Return to Q's 1 & 2 on your worksheet and review. Then, in the corresponding space provided, describe the strengths of one of your current HR strategies/practices

2. Which items listed in Q's 1 & 2 were not selected? Pick one strategy/practice you could implement with some ease & draft a SMART goal to achieve it. Capture anticipated barriers/challenges

3. **FOR LATER:** Critically examine and reflect on how you, your profession, and/or your community have contributed to the systems-level harm(s) experienced by PWUD (Section 6)

CHALLENGE THE STATUS QUO

At times there are real structural barriers to implementing policies/initiatives. Other times it is the mere perception of limitations, an absence of understanding, feelings of disempowerment, or a lack of communication that stalls progress. We need to identify our individual & collective power as agents of influence to realize change in our environments.

1. Return to Q's 3, 4 & 5 on the worksheet and review your responses. Then, blank space provided, describe how you and/or your org currently leverage indicated powers to influence individuals/groups along a desired course of action. How did you/they do it ? Your response does not necessarily have to be related to harm reduction.

2. Now think about a more substantial harm reduction initiative that interests you. Capture who in your org/field/community has access to the power required to influence a favorable outcome, what is your relationship to them? Who else outside your org is already doing similar work and how do they approach it? What is your relationship with them like? What power(s) do you already have access to, how can you leverage them? Who else do you need to connect with in order to take action?

3. **FOR LATER:** Reflect on the ways in which you, your org, or community might exercise coercive power in order to get others to comply. Are alternatives to punitive measures possible? Speak with your colleagues. Next, think about norms & policies in your practice, organization, or community that, if adjusted, would increase current HR capacity. Speak with your colleagues. (Section 6)

COLLABORATE (AND BE INCLUSIVE)

More often than not people, professions, and organizations work in silos. As discussed, substance use is a complex phenomenon driven by and compounded by myriad individual and external factors. Building harm reduction capacity requires disparate groups working together, which includes those most impacted by the problem-both those with lived **and** living experience

1

Using your response from Box 2 of the previous section, label the icons with the individuals & orgs you noted. Besides access to power, what valuable skillset and/or perspective do they bring to the table?

2

What do you notice about the composition of those you have assembled around your table? Prompts: Mostly professionals? Similar sectors? Similar demographic characteristics/*social location*?

An individual's social location is a combination of categories, factors , or attributes such as race, age, ability, immigration status, class status, gender identity, language, sexual orientation, employment, and religion

CREATIVELY PROBLEM SOLVE

At this point, we've identified potential "teammates" based on access to power and specific skill sets/experiences. Now let's explore the traits of the best problem-solving teams; ***cognitive diversity*** and ***psychological safety***.

Teams that are **cognitively diverse** (have different information processing styles) benefit from more creativity, higher quality solutions, are better able to predict obstacles, and outperform homogeneous teams when problem-solving or faced with ambiguous challenges.

Psychological safety-the belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes and it is crucial to realizing the potential and power of cognitive diversity in teams.

1

Using Box 2 from of the previous section, reflect on the team you have assembled. Note who (individuals/groups/perspectives) do you think is missing? Add them to your table.

2

FOR LATER: Reflect on your access to power(s) and those of your collaborators. What are some ways that you could use your power to positively influence the psychological safety of your assembled HR strategy team?

CEDE THE POWER

Equitable collaboration requires the inclusion of PWUD and centers their experiences, needs, desires and dignity. This involves recognition of inherent power imbalances and the ensuing action taken to shift imbalances. It requires time, people move at "the speed of trust".

Examples of meaningful inclusion & ceding power include but are not limited to: participation of PWUD from project inception (not just approached as vectors of information/for feedback after the fact), giving voice and a vote (decision-making power), making accommodations to support the involvement of PWUD, and compensating PWUD fairly & adequately for their participation.

1

Consider imbalances at play in your current and tentative HR initiatives. Identify 3-5 ways that you, your org, and/or community can start to meaningfully involve PWUD and begin shifting power

(Winkelstein, 2023)

SMALL GROUPS SHARE-OUTS

In Pairs or Small Groups, Discuss Your Worksheet Responses

Please do not pair or group with people you know, who have a similar occupation, or are from your own organization if

THANK YOU!

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